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## **Creating Connections - Health, Community and Residential Care Assessments**

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## Creating Connections - Health, Community and Residential Care Assessments

### Abstract

Health - multiple program and service types. - primary, secondary, tertiary and super-speciality levels  
Community Care - multiple programs and service types -including extended aged care in the home packages  
Residential Care -residential programs with various levels of care

### Keywords

care, assessments, community, health, residential, creating, connections

### Disciplines

Business

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# Creating Connections - Health, Community and Residential Care Assessments

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ACS 2003 Residential Care Conference, 1 August 2003

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## 3 sectors

### ◆ Health

- multiple programs and service types
- primary, secondary, tertiary and super-specialty levels

### ◆ Community Care

- multiple programs and service types
- including extended aged care in the home packages

### ◆ Residential Care

- residential programs with various levels of care

**Creating  
connections?**

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## Multiple assessments, assessment systems and their many purposes - 1

- ◆ Intake, entry point and placement function
- ◆ Eligibility for program(s)
- ◆ Needs - screening, specialist, comprehensive
- ◆ Occupational health and safety - risks & service arrangements
- ◆ Referral, care packaging and service coordination planning

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## Multiple assessments, assessment systems and their many purposes - 2

- ◆ Assigning priority for receiving a service, a placement, or aids and appliances
- ◆ Periodic reassessment
- ◆ Managing waiting lists, etc ...

All can use common tools, data items combined in different ways for different purposes

All purposes require their own intelligent business rules

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## National policy context (today)

- ◆ Australian Health Care Agreements
  - no agreement yet
- ◆ New Strategy for Community Care
  - no agreement yet
- ◆ Residential Care
  - Commonwealth Review of RCS, March 03, with C'wealth response and work in progress
  - Pricing Review, in process
- ◆ Review of the role of Divisions of General Practice, July 03
  - C'wealth response in progress

**All  
occurring  
in parallel**

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## NSW policy and IS context (today)

- ◆ Better Service Delivery Program
  - NSW funded human services, community care, including HACC and Community Health
  - Electronic Referral trial
- ◆ NSW Comprehensive Assessment trials
  - HACC (+ health, aged care, disability)
- ◆ CHIME
  - Community health information system
- ◆ Medical Director
  - GP information system

**Residential  
Care  
not in the  
loop**

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# The bigger structural problem

## Commonwealth

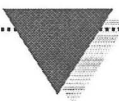
- ◆ Health
  - Doctor (CMBS)
  - Drugs (CPBS)
  - Health insurance
- ◆ Aged Care
  - Residential Aged Care
  - Community (17 programs)
- ◆ Veterans

## NSW

- ◆ Health
  - Hospitals
  - Community health
  - Rehabilitation and aged care
  - 7 other programs
- ◆ Disability, Ageing and Home Care
  - HACC
  - Disability

**5 Ministers, 4 departments, about 80-90 programs (?)  
multiple parallel universes**

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**But important steps in the right direction**

that couldn't wait for a coherent policy context

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## Key message

- ◆ A coherent policy context can help a lot, by clarifying aims and objectives, and forging common strategies
- ◆ But there is no point waiting for that context to come about.

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## 2000-2002

- ◆ **National functional dependency study.** Outcome:
  - a 2 tiered system, a national HACC functional screening tool (1st tier) and functional assessment tools (2nd tier)
  - concern that function, alone, isn't enough.
- ◆ **Victorian Better Access to Services (BATS).** Outcome:
  - Victorian Initial Needs Identification (INI) tools
  - screening for more than just function.
- ◆ **South Australian ERA project.** Outcome:
  - South Australian refinement of Victorian (INI) tools
  - other field trials in SA.

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## 2002-2003

- ◆ **Mid North Coast ATSI CCT.** Outcome of planning phase:
  - INI becomes Ongoing Needs Identification (ONI) to reinforce that needs identification *begins* at referral or first contact, but does not end there. It is the front end to a system that is ongoing.
- ◆ **Test of functional tools with ATLAS population in NSW**
  - 2002 - Screening by teachers, assessments by CRS, analysis of data on four cohorts of school leavers 1999, 2000, 2001, 2002.
  - 2003 - HACC functional screen and behavioural assessment incorporated as standard practice in ATLAS registration process.
- ◆ **NSW Comprehensive Assessment pilots**
  - six regional pilot sites plus Home Care Service regional assessment centres (Sydney and Newcastle). Agency and system impacts, priority rating

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## 2002-2003

- ◆ **Queensland ONI and Service Priority Rating Tool**
  - Queensland demonstration projects and system implementation
  - Final version of ONI being evaluated - now well bedded down
  - Service Priority Tool using information collected in the ONI.
- ◆ Specific applications also being tested in smaller scale research and planning studies - carers, autism service coordination planning, home medicines support, community transport screen, etc
- ◆ Plus lots of other community care agencies have just got on with it and are now using these common tools!

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## **Key messages**

- ◆ An evolving approach to reform, with each project informing the next and a growing momentum
- ◆ Each project is forming a piece of a developing jigsaw
- ◆ Each project has 2 purposes:
  - improve local practice
  - contribute to the evolving bigger picture

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## **Key messages**

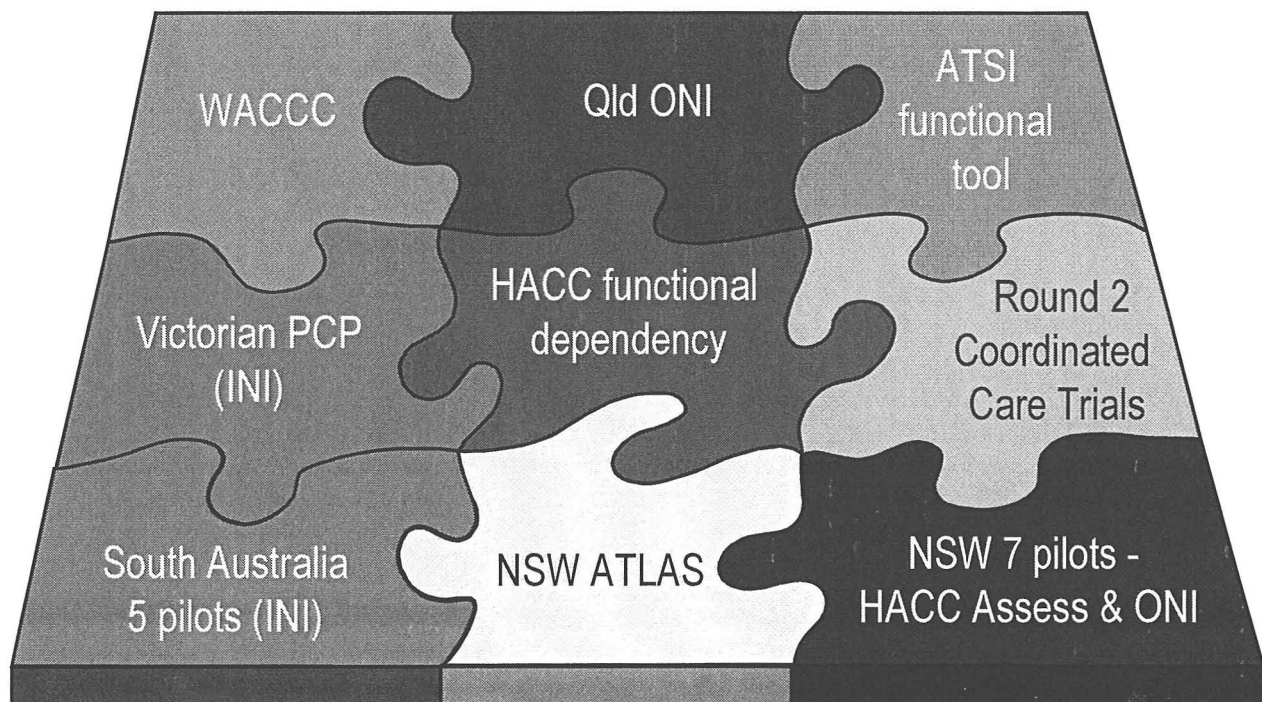
- ◆ Practice and evidence-led, not centrally developed and top down
- ◆ Pilots and demonstration sites are not at the receiving end of a final product, they are helping to develop a systematic set of steps towards an improving final product
- ◆ No one is in charge

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## Key messages

- ◆ Centrally determined policy does not always drive change
- ◆ Service providers know that they can't wait for a sensible policy climate and are just getting on with the job
- ◆ Information technology is designed to capture information
  - that, in the ideal world, is policy driven and evidence based
  - but is now being driven by practice and evidence
    - ▼ eg, the HACC functional dependency tools (and now the full ONI) are being incorporated into HSNET (BSDP), CHIME (community health), Medical Director (GP)
- ◆ One day (hopefully) policy will catch up

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## A bigger picture - creating connections

Collecting and using information to  
solve bigger problems

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## Caveats

- ◆ There is a difference between:
  - findings (that are based on research and evaluation evidence) and
  - lessons (that can be drawn from demonstrations, reviews, QA activity and surveys of practice)
- ◆ Lessons are useful in guiding business rules (what will work where)
- ◆ Evidence needs to accumulate over time to be useful

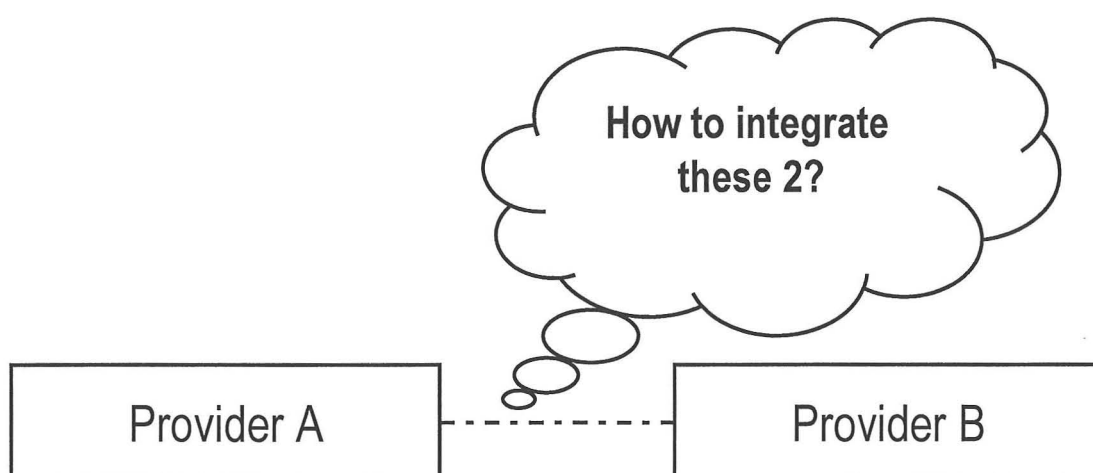
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## Usefulness beyond HACC

- ◆ Tools have been tested in range of international studies and have been found to be useful for adult clients with functional dependency needs, irrespective of funding program
- ◆ Same domains, but different tools, are already in common use in program areas such as mental health, disability, residential care etc
- ◆ **Now being incorporated into broader community care screening and assessment tools and as tools to develop 'virtual' organisations**
- ◆ But community care only at this stage - should res care be in the loop?

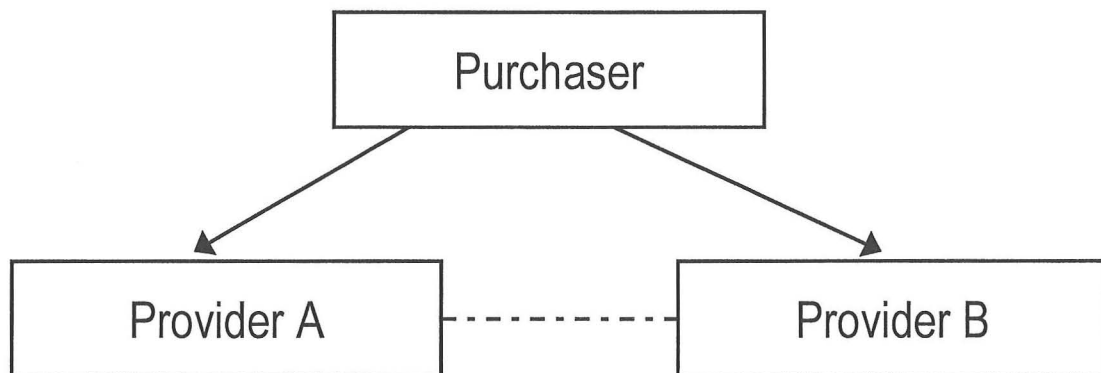
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## The problem



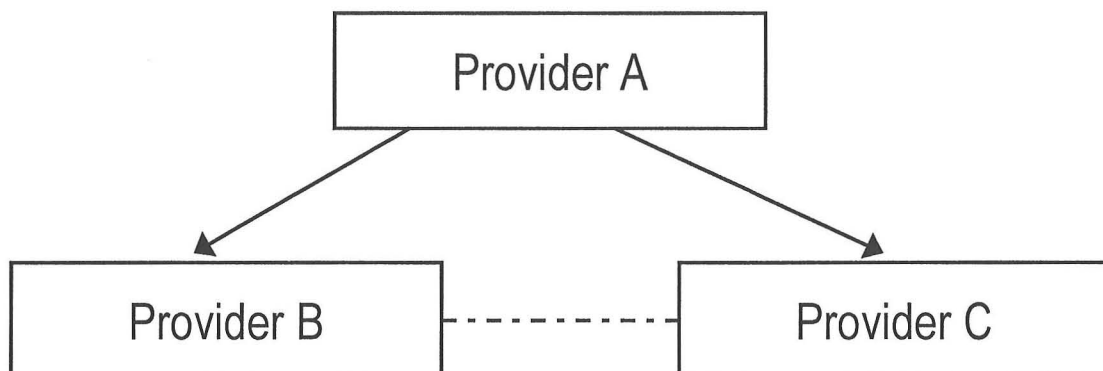
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## The solution (1) - purchaser provider split



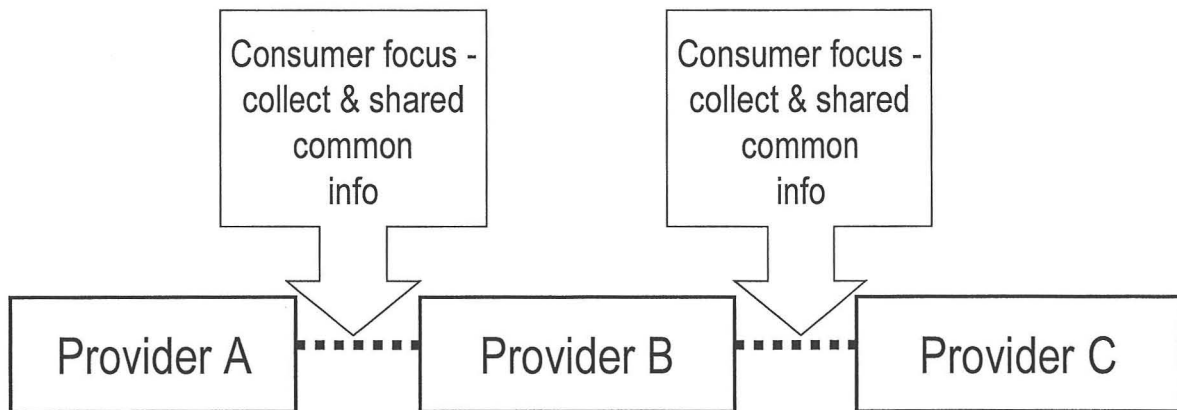
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## The solution (2) - provider as fund holder



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## The solution (3) - virtual organisations



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## Ideas behind virtual organisations


- ◆ Consumers (patients, clients) should not have to tell their story numerous times, should be able to access the system at any point, and have the opportunity to receive care from providers who actually know what the system as a whole is doing
- ◆ With their consent, information should be collected only once and shared between providers involved in their care:
  - includes having eligibility and needs screened (assessed) across service types, funding programs and sectors in one go

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## More important ideas

- ◆ Providers should be 'joined up working' not 'joined up worrying'
  - shift the focus from worries about take-overs, control, power, constant reorganisation etc
  - to a focus on common interests - the consumer and their outcomes
- ◆ Integration strategies should not be driven by IT:
  - no more tail wagging dog!
  - IT is just a tool that helps it happen in more efficient ways

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The big question - where does NSW  
(policy makers, providers and consumers)  
want to be in 3 years time?

This might also be a big question for the  
Commonwealth!

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# Key Issue 1

## 2 options/ 2 cultures

1. Different assessments for different programs and services, each focusing on eligibility and need for that specific program or service.
2. Common assessment across programs and services, assessing eligibility and need across the lot.

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# Key Issue 2

## If common, common to what? Scope:

- ◆ HACC + aged care
  - ◆ HACC + aged care + community health
  - ◆ HACC + aged care + community health + GP
  - ◆ Disability, mental health, children's services, drug & alcohol, dental, hospital (emergency, outpatients, inpatients)
- 
- Primary and community care sector
- Secondary referral sector

**Where does Residential Care fit?**

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## Leutz's 5 laws of integration

- ◆ You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people
- ◆ Integration costs before it pays
- ◆ Your integration is my fragmentation
- ◆ You can't integrate a square peg and a round hole
- ◆ The one who integrates calls the tune

◆ Leutz, W. (1999) Five laws for integrating medical and social services: lessons from the United States and the United Kingdom, *The Milbank Quarterly*, 77, 77-110

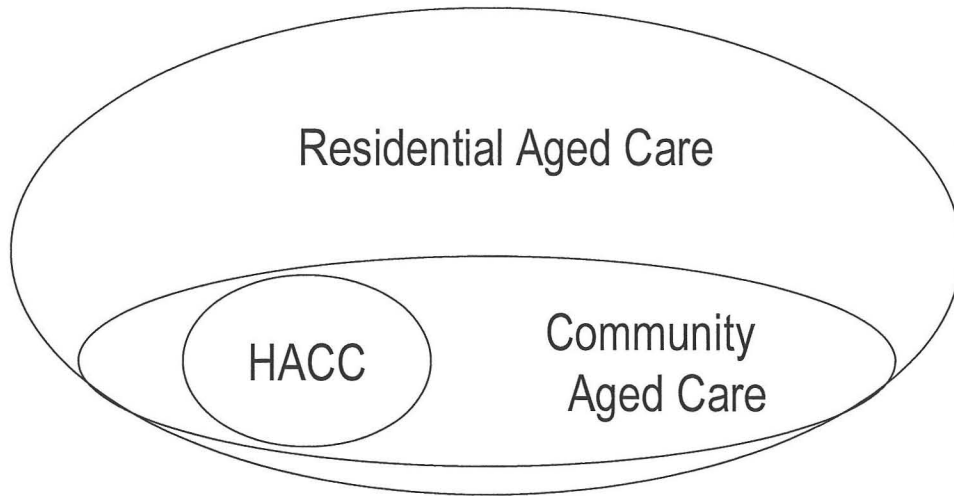
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You can have this:



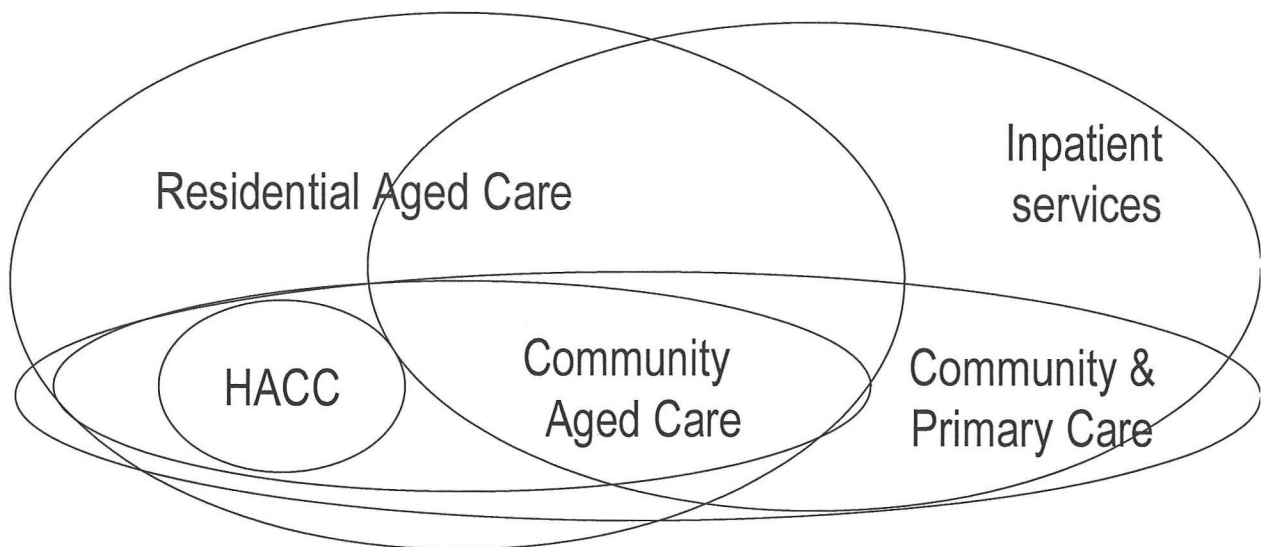
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Or maybe this:



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But you can't have it all:



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## Key Issue 3

### What's in common?

- ◆ Initial Contact Information
  - Client registration
  - Service Entry Data Set
- ◆ Ongoing Needs Identification (ONI) - screening
- ◆ Initial Action Plan
- ◆ Assessment - different types
- ◆ Care Plan
- ◆ Service Coordination Plan

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### Scope of approaches in the NSW pilots

Scope of processes included		Level 1	Level 2	Level 3	Level 4
Scope of participating agencies		Functional screen	Functional assessment	Ongoing Needs Identification	Service Coordination Plan
Level 1	HACC	Minimum scope of pilots			
Level 2	Level 1 + Aged care	Optional scope of pilots			
Level 3	Level 2 + Community health				
Level 4	Level 3 + GP				
Level 5	Level 4 + Specialist health & community care				

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## Key Issue 4

**What, if anything, should be separated from service provision?**

- ◆ Initial Contact Information
  - Client details / registration
  - Service Entry Data Set
- ◆ Ongoing Needs Identification (ONI) - screening
- ◆ Initial Action Plan
- ◆ Assessment - different types
- ◆ Care Plan
- ◆ Service Coordination Plan

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**National/State consistency versus  
inventing local versions of the wheel**

- ◆ You can't have both!
- ◆ Comparability and efficiency versus acceptability
- ◆ Local ownership of processes rather than tools

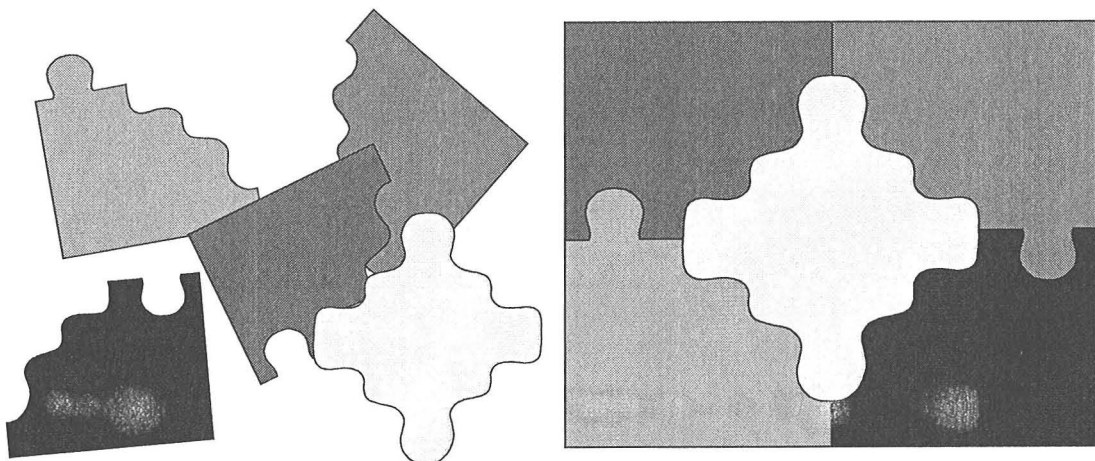
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## Conclusions

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The future - 2 possibilities!

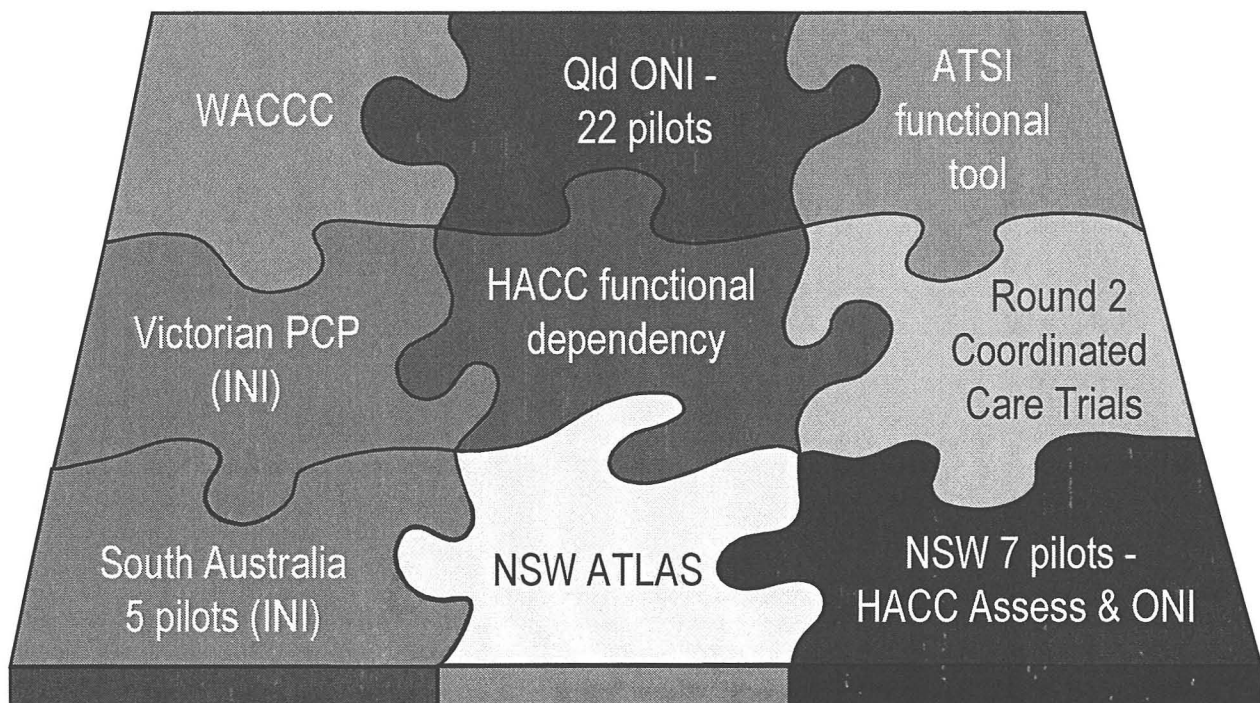


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## Bits of the jigsaw

- ◆ Assessment should be an ongoing process rather than a one-off event
- ◆ If the goal is to rationalise assessment, measure needs and outcomes and make it easier for consumers, then a separate assessment model for each funding program doesn't make sense
- ◆ Virtual organisations show promise...
- ◆ But only as one bit of the jigsaw
- ◆ Leutz is probably right

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Websites for more information:

CHSD      [www.uow.edu.au/commerce/chsd](http://www.uow.edu.au/commerce/chsd)

ERA        [www.eraproject.sa.gov.au](http://www.eraproject.sa.gov.au)

VIC        <http://hnb.dhs.vic.gov.au/acmh/phkb.nsf>